STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3091AGC	A. BUILDING _____ B. WING _____	C 10/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGE AT PARADISE VALLEY ASSTD LIVING	2205 EAST HARMON AVE. LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28276 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation initiated on 9/4/09 and completed 10/9/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 91 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, eighty-one (81) Category I residents and ten (10) Category II residents. The census at the time of the survey was 72. Four resident files were reviewed. Complaint #NV00022920 was substantiated. See Tag Y878 Complaint #NV00022942 was substantiated. See Tag Y878 and Y743 The following deficiencies were identified:	Y 000		
Y 743 SS=D	449.272(2) Indwelling Catheters NAC 449.272 2. The caregivers employed by a residential facility with a resident who requires the use of an indwelling catheter shall ensure that: (a) The bag and tubing of the catheter are changed by: (1) The resident, with or without the	Y 743		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 743	Continued From page 1 assistance of a caregiver. (2) A medical professional who has been trained to provide that care. (b) Waste from the use of the catheter is disposed of properly. (c) Privacy is afforded to the resident while care is being provided; and (d) The bag of the catheter is emptied by a caregiver who has received instruction in the handling of such waste and the signs and symptoms of urinary tract infections and dehydration. This Regulation is not met as evidenced by: Surveyor: 28276 Based on interview on 9/3/09, the facility failed to ensure the caregiver of 1 of 1 residents who had an indwelling catheter complied with NAC 449.272 (Employee #3). Findings include: Resident #2 had an indwelling catheter. During interview on 9/4/09, Employee #3 was unable to articulate the signs and symptoms of a urinary tract infection or dehydration for a resident with a catheter. The facility Registered Nurse and the General Manager reported they believed caregivers were given training related to catheters. Review of the hospice notes dated 8/18/09 revealed Employee #3 received information related to cleaning the skin around the Foley catheter. There was no documentation the caregiver received instruction on the signs and	Y 743		

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Y 743	Continued From page 2 symptoms of urinary tract infection or dehydration. Severity: 2 Scope: 3	Y 743		
Y 878 SS=H	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 9/3/09 through 9/4/09, the facility failed to ensure 1 of 4 residents received medications as prescribed (Resident #1). Findings include: Resident #1 was prescribed the following medications: - Omeprazole 20 milligrams (mg) one capsule by mouth every day - Timolol Maleate 0.5% drops one drop in both eyes every morning - Senna Plus 8.6 mg-50mg one tablet by mouth	Y 878		

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Y 878	Continued From page 3 twice daily - Albuterol Sulfate 0.83 mg/1 milliliter (ml) one unit via small volume nebulizer (svn) every six hours while awake - Ipratropium Bromide 0.2 mg/ml solution one unit via svn every six hours while awake - Travatan Ophthalmic 0.004% drops instill one drop at bedtime in both eyes - Restoril 15 mg as needed (PRN) - Albuterol Sulfate 0.83 mg/1 ml PRN - Ipratropium Bromide UD 0.2 mg/ml solution PRN - Milk of Magnesia 400 mg/5 ml PRN - Lorazepam 0.5 mg PRN - Roxanol 20 mg/1 ml solution PRN - Roxanol 20 mg/1 ml PRN - Roxanol 40 mg/1 ml PRN - Promethazine HCL 25 mg PRN - Senna Plus 8.6 mg-50 mg PRN - Acetaminophen 650 MG suppository PRN (administered by hospice). On 8/19/09 at approximately 6:00 AM, Employee #5 poured pills prescribed for Resident #5 and gave the pills to Resident #1. On 8/19/09 at 8:00 AM, Employee #3 went to give Resident #1 prescribed morning medications and Resident #1 stated a male medication technician (Med Tech) already gave her the morning medications including an additional green pill. Employee #3 completed a Medication Error Report which stated the resident was tired all day, Employee #3 took her blood pressure at 12:30 PM with a reading of 71/42, and then called hospice nurse. On 8/19/09, Employee #2 wrote a letter to Employee #5 stating Resident #1 ingested two pills that lower blood pressure and Neurontin 300	Y 878		

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Y 878	Continued From page 4 mg (anti-epileptic) all medications that belonged to Resident #5. On 9/3/09 at 9:20 AM, the hospice nurse for Resident #1 was interviewed and stated she received a call from Employee #3 who reported Resident #1 ingested medications that were prescribed for another resident. The hospice nurse reported Resident #1 took Neurontin 300 mg, Hydralazine HCL 100 mg and one additional medication. The hospice nurse reported she arrived at the facility and took Resident #1's blood pressure several times. The blood pressure readings ranged from 71/42 to 91/52, and her heart rate ranged from 52 to 54 beats per minute (BMP). The hospice nurse eventually called her supervisor and the physician and obtained permission to transport Resident #1 to the hospital. Emergency room records from Desert Springs Hospital indicated Resident #1 was admitted 8/19/09 at 4:16 PM with a diagnosis of ingestional error. The Emergency Nursing Record recorded Resident #1's chief complaint as "given BP meds & BP dropped", and blood pressure on admittance was 110/70. The Emergency Physician Record Dizziness form from Desert Springs Hospital noted patient was given 100 mg hydralazine and 50 mg metoprolol, medications that were not hers. According to the nursing notes from Desert Springs Hospital Resident #1 was discharged 8/19/09 at 8:30 PM and taken by ambulance back to the facility. Severity: 3 Scope: 2	Y 878		